

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001136 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 12/22/2015 |
| NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00188733.</p> <p>Complaint IN00188733- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: December 22, 2015</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Other: 125 Total: 125</p> <p>Sample: 3</p> <p>Lake Park Residential Care was found to be in compliance with 410 IAC 16.2-5.1 in regard to the Investigation of Complaint IN00188733.</p> <p>Quality review completed by 26143, on December 23, 2015.</p> | R 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE